FINAL

MARYLAND MEDICAID
CMS 1500 FORM BILLING INSTRUCTIONS FOR
PRIVATE DUTY NURSING AND SHIFT HOME HEALTH AIDE/CERTIFIED NURSING ASSISTANT SERVICES

PROGRAMS INVOLVED:

EPSDT-PRIVATE DUTY NURSING
MODEL WAIVER
RARE AND EXPENSIVE CASE MANAGEMENT (REM)

THESE INSTRUCTIONS ARE FOR PAPER CLAIMS ONLY

Maryland Medicaid Billing Instructions for
EPSDT-Private Duty Nursing and REM Optional Services

These billing instructions are for billing paper claims only.
These services are billed on the CMS 1500 form.

For information on electronic billing, please refer to the EPSDT- Private Duty Nursing and REM section of the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: "Professional 837".

BILLING TIME LIMITATIONS

Invoices must be received within nine (9) months of the date of service on the invoice. If a claim is received within the 9-month limit but rejected, resubmission will be accepted within 60 days of the date of rejection or within 9 months of the date of service, whichever is longer. If a claim is rejected because of late receipt, the patient may not be billed for that claim. If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted.

OTHER THIRD PARTY RESOURCES

All other third-party resources should be billed first and payment either received or denied before the Medical Assistance Program may be billed for any portion not covered. However, if necessary to meet the 9-month deadline for receipt of the claim(s), the Medical Assistance Program may be billed first and then reimbursed if the third-party payor makes payment later.

It is preferred that invoices be typed. If printed, the entries must be legible and in black or blue ink only. Do not use pencil or a red pen to complete the invoice, otherwise payment may be delayed or the claim rejected. The instructions which follow are keyed to the form locator number and headings on the CMS 1500 form.

Completed invoices are to be mailed to the following address:

Maryland Medical Assistance Program
Division of Claims Processing
P. O. Box 1935
Baltimore, MD 21203

Maryland Medicaid CMS 1500 Form Billing Instructions for Model Waiver, EPSDT- Private Duty Nursing and REM Optional Services

Note: These instructions are for paper submission on the CMS 1500 only.

Field	Title	Action
1	Claim Type	Optional
1a	Insured's ID Number	Not required (Medical Assistance (MA) 11 digit ID number is required in 9a).
2	Patient's Name	Enter the patient's name from the MA identification card.
3	Patient's Birth Date	Optional
4	Insured's Name	Optional
5	Patient's Address	Optional
6	Patient's Relationship to Insured	Optional
7	Insured's Address and Telephone #	Optional
8	Patient Status	Not required.
9	Other Insured's Name	Not required.
9a	Other Insured's Policy or Group	Enter the patient's 11 digit MA number as it appears on the MA identification card.
9b	Other Insured's Date of Birth	Not required.

Field	Title	Action
9c	Employer's Name or School Name	Not required
9d	Insurance Plan Name or Program Name	Not required.
10a – 10c	Patient's Condition Related To	Optional
10d	Reserved for Local Use	Not required.
11	Insured's Policy Group or FECA Number	If the patient has other third party insurance and the claim has been rejected by that insurer, enter the appropriate rejection code of "K" in this field.
11a	Insured's Date of Birth	Not required.
11b	Employer Name or School Name	Not required.
11c	Insurance Plan Name or Program Name	Not required.
11d	Is There Another Health Benefit Plan?	Not required.
12	Patient or Authorized Person's Signature	Not required.

Field	Title	Action
13	Insured’s or Authorized Person’s Signature	Not required.
14	Date of Current Illness, Injury, Pregnancy	Not required.
15	If Patient has had same or similar illness, give first date	Not required.
16	Dates Patient unable to work in current occupation	Not required.
17	Name or referring physician or other source.	For service which involves a requesting, referring, ordering, or prescribing practitioner. Enter the practitioner’s name and degree.

Field	Title	Action
17a	I.D. Number of Referring Physician	Enter the MA provider number of the referring provider. If the referring physician's MA provider number is unknown enter the numbers 000005100 in this field.
18	Hospitalization Dates Related to Current Services	Not required.
19	Reserved for Local Use	Enter the MA provider number of the practitioner rendering the service. In some instances, the agency's rendering provider number may be the same as the payee provider number in Block 33. If the pay to provider # in field 33 is a group practice, then the rendering provider# is required.
20	Outside Lab	Not required.
21	Diagnosis or nature of illness or injury	**This is a required field.** Enter the 3rd, 4th or 5th character code from the ICD-9 related to the procedures, services or supplies listed in Block

Field	Title	Action
		Line 1 and secondary diagnosis on Line 2. Additional diagnoses are optional and may be listed on lines 3 and 4.
22	Medicaid Resubmission Code	Not required.
23	Prior Authorization Number	**This is a required field.** Enter the preauthorization number as it appears on the authorization letter.
24a	Date(s) of Service	**This is a required field.** Enter the six (6) digit numeric date of service (e.g. 10/01/03) under the “From” heading Leave the space under the “To” heading blank. **Each date of service on which a service was rendered must be listed on a separate line. Ranges of date are not accepted on this form.**
24b	Place of Service	For each service, enter the appropriate place of service code. Refer to the Maryland Medicaid Value Descriptions (attached). Use the value of **12** for patient’s residence. When

Field	Title	Action
		services are rendered to the client outside the home use **99** as the value.
24c	Types of Service	Not required.
24d	Procedures, Services or Supplies	**This is a required field.** Enter the five (5) character HCPCS procedure code. In addition, for those **individuals sharing a nurse the "TT" modifier must be indicated.**
24e	Diagnosis Code Indicator	**This is a required field.** Enter a single or any combination of diagnosis items (1,2,3,4) from Block 21 above for each line item on the invoice.
24f	$ Charges	**This is a required field.** Enter your usual and customary charge. Do not enter the Maryland Medicaid maximum fee unless that amount is your usual and customary charge. If there is more than one unit of service on a line, the charge for that line should be the total for all units.

Field	Title	Action
24g	Days Units	**This is a required field.** Enter the number of units of service for each procedure. The number of units must be for a single visit or day. Multiple, identical services rendered on different days should be billed on separate lines.
24h	EPSDT/Family Plan	Not required.
24i	EMG	Not required.
24j	COB	Leave blank.
24k	Reserved for Local Use	Leave blank.
25	Federal Tax ID#	Not required.
26	Patient's Account#	Not required. However, it is recommended that providers place their patient account number or some other information in this field to identify the patient should the patient's MA number be incorrect. In that instance, MA will send the information

Field	Title	Action
		back to you on your Remittance Advice.
27	Accept Assignment	Not required.
28	Total Charges	Enter sum of the charges shown on all lines in Block 24f.
29	Amount Paid	**Enter the amount of any collections received from any Third Party payor except Medicare.** If the patient has Third-Party insurance and the claim has been rejected, the appropriate rejection code must be entered in Block 11. Collections from patients are not appropriate.
30	Balance Due	Not required.
31	Signature of Physician or Supplier	Not required.
	Date Billed	**This is a required field.**
32	Name and Address of facility where services were rendered	Not required.

Field	Title	Action
33	Physician's, Supplier's Billing Name, Address, ZIP Code and Phone#	**This is a required field.** Enter the name, street address, city, state and ZIP code to which claims may be returned as well as a telephone number. The MA provider number to which payment is to be made **MUST** be entered in the lower right corner of this block to the **IMMEDIATE RIGHT OF THE WORDS GRP. #** Errors or omissions of this number will result in non-payment of your claims.

NOTE: Please preview the following page to assure that you have not made any of the common errors which are made when filing claims to MA. Any of these three errors will result in your claim/claims not being processed.

Attachments